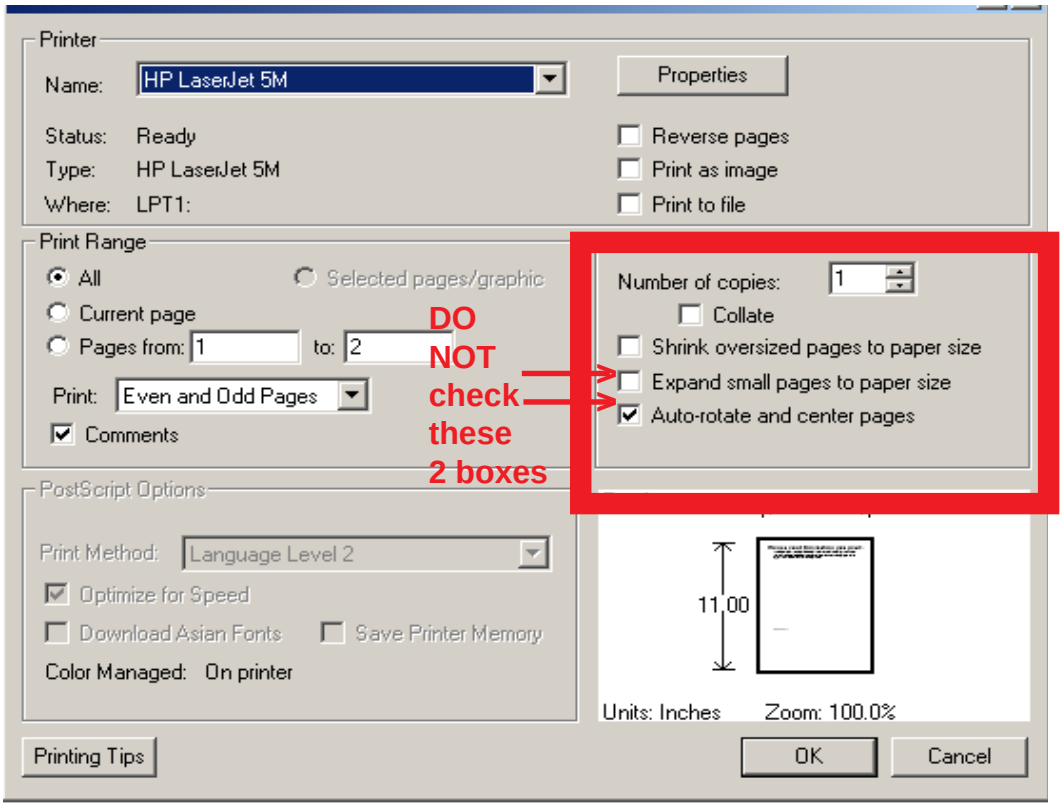
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



(This page intentionally left blank.)

Washington State Department of Health
Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Midwifery Application Packet

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.

* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Midwifery

DEPOSIT SLIP

NAME (PLEASE PRINT) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ **Check**
☐ **Money Order**

DOH 679-127 (REV 8/2003)

1F 0252130000 00386

(This page intentionally left blank.)

Washington State Department of Health
Health Professions Quality Assurance
Midwifery Program
P.O. Box 1099
Olympia, WA 98507-1099

Application Instructions For Licensed Midwife

To qualify for licensure as a direct entry midwife in the state of Washington, one must have graduated from a program approved by the Department of Health and pass the State Approved Examinations. A list of approved programs is included in the packet. Applicants licensed in another state may be eligible to be credentialed without examination if the Department of Health determines that the other state's credentialing standards are substantially equivalent to the standards in Washington State (more information is included).

A candidate who has received a certificate or diploma from a foreign institution on midwifery of equal requirements conferring the full right to practice midwifery in the country in which it was issued may qualify to take the licensure examination.

The Midwifery Licensure Examination is offered twice a year in February and August. The examination is administered on the third Wednesday of the month. The applications must be received 45 days prior to the examination. The NARM applications and the required fee must be submitted directly to NARM.

Original Applicants Must Submit:

1. Completed Midwifery Application Form. Carefully read and respond to the information requested in the Personal Attestation on the last page.
2. Submit Applicable fee(s).
3. One current passport type photograph (2 x 2 inches). Sign across the bottom of the photo or on the back. Instant pictures (Polaroids) are not acceptable.
4. Documentation required for "yes" answers for any of the personal data questions.
5. Two letters of recommendation (form enclosed).
6. Certification/documentation of seven (7) hours AIDS education as described on the form.
7. Proof of completion of high school or equivalent. This may be verified by your midwifery program.
8. Transcripts sent directly from your school indicating that you have received a Midwifery Certificate.

   Note: Transcripts verifying your midwifery certificate must be received before you will be admitted to the examination.
9. Current Plan For Consultation, Emergency Transfer, And Transport.

   Note: Midwifery license will not be issued without a current plan.

10. Applicants with disabilities who wish to request special accommodations must do so when submitting their application. All applications and special accommodation requests must be received 45 days prior to the examination.

Foreign Applicants:

In addition to the above documentation, applicants who have graduated from foreign institutions on midwifery must provide:

1. Documentation sent directly from the midwifery school which shows course curriculum. If the transcripts are in a foreign language, they must be transcribed.
2. Documentation sent directly from the country in which you obtained your midwifery certificate, showing that you were licensed to practice midwifery in that country.
3. Course content form for Required Midwifery Courses.

Note: Applications from applicants who have graduated from midwifery schools in a foreign country will take longer to process due to the review of the midwifery program. The secretary of the Department of Health must verify that the foreign midwifery program is of equal requirements to programs accredited by the Secretary.

Midwifery Examination:

When a completed application is received, the information will be reviewed to determine eligibility for examination. All eligible applicants will be notified approximately two weeks prior to the examination of the date, place and time to appear.

Additional Information:

If an applicant has had a name change or documents were issued in a name other than the one currently being used, please indicate those names when submitting the application file.

Candidates who pass the examination will be issued a license to expire on the next birth anniversary date at which time it will be renewable. At the time of renewal, a new written plan for consultation, emergency transfer and transport will be required. The current renewal fee is $950.00.

Candidates who do not successfully pass the examination may be reexamined at any regular examination within one year without payment of an additional fee. If the second examination is also unsuccessful, another new examination fee will be required.

For Additional Application Information:

Please contact: Department of Health
Midwifery Program
P.O. Box 47864
Olympia, WA 98504-7864

(360) 236-4721

Washington State Department of Health
Health Professions Quality Assurance
Midwifery Program
P.O. Box 1099
Olympia, WA 98507-1099

Fees For Application and Examination

NARM Examination:

The Department of Health has adopted the national examination offered by the North American Registry of Midwives. There will also be a State add-on examination. The NARM examination is offered twice a year in February and August. The examination is administered on the third Wednesday of the month. The cost for this examination is as follows:

State Application ..... $500, payable to the Department of Health.

NARM Examination: ..... $700, payable directly to NARM (as of January 1, 2001). The NARM application packet is enclosed. You will need to complete the application and send it along with the $700 fee directly to NARM.

NARM Administration Fee: ... $100, payable to the Department of Health

State Add-on Examination: ... $150, payable to the Department of Health

The state application and $750 must be submitted to:

Department of Health
PO Box 1099
Olympia, WA 98504-1099

The NARM application is also enclosed. This must be submitted directly to NARM with the fee of $700.

Candidates who obtain the NARM application on the Department of Health website may obtain the NARM Candidate Information Bulletin and the NARM *How To Become A Certified Professional Midwife* booklet from the NARM website at: www.narm.org.

Washington State Department of Health
Health Professions Quality Assurance
Midwifery Program
P.O. Box 1099
Olympia, WA 98507-1099

Approved Midwifery Schools

Bastyr University
14500 Juanita Drive NE
Bothell, WA 98011

(206) 823-1300

National College of Naturopathic Medicine
11231 SE Market
Portland, OR 97216

(503) 255-4860

Seattle Midwifery School
2524—16th Avenue S
Seattle, WA 98144

(206) 322-8834

DOH 679-123 (REV 8/2003)

Washington State Department of Health

Health Professions Quality Assurance
Midwifery Program
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY	
VALIDATION	DATE RECEIVED
LICENSE #	ISSUANCE DATE

LICENSE #

Application For Midwife

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

NOTE: Application fee is Non-Refundable. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME LAST FIRST MIDDLE INITIAL

MAILING ADDRESS

CITY | STATE | ZIP | COUNTY

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.)
( )

SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)
— —

GENDER ☐ Male ☐ Female | BIRTHDATE (MO/DAY/YR) / / | PLACE OF BIRTH

HEIGHT | WEIGHT | EYE COLOR | HAIR COLOR

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list full name(s)

2. Previous Licensure

List all states where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. (Attach additional 8 1/2 x 11 sheet if necessary.)

STATE/JURISDICTION	PROFESSION	LICENSE TYPE	LICENSE		METHOD OF LICENSURE	CURRENTLY IN FORCE
			YR ISSUED	NUMBER		
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes

3. Education

In the spaces below, provide a chronological listing of your educational preparation and post-graduate training. (Attach additional 8 1/2 x 11 sheet if necessary.)

FULL NAME, CITY AND STATE SCHOOLS ATTENDED	DEGREE EARNED	ATTENDANCE	
		ENTRANCE DATE	ENDING DATE

4. Personal Data Questions

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐
4. Are you currently engaged in the illegal use of controlled substances?	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☐
b. a charge of a sex offense?	☐	☐
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☐
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☐
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☐
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☐

5. Professional Experience

In chronological order, list all professional experience. (Exclude activities listed under other sections.) (Attach additional 8 1/2 x 11 sheet if necessary.)

INDICATE NATURE OF EXPERIENCE OR PRACTICE AND LOCATION	INCLUSIVE DATES OF EXPERIENCE	
	BEGINNING DATE	ENDING DATE

6. AIDS Education and Training Attestation

I certify I have completed the minimum of seven (7) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

7. Applicant's Attestation

I, _____ , certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

_____ _____
SIGNATURE OF APPLICANT DATE

Attach Current Photograph Here.
Indicate Date Taken and Sign in Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

Official Use Only

Washington State Records Center

Washington State Department of Health
Health Professions Quality Assurance
Midwifery Program
P.O. Box 1099
Olympia, WA 98507-1099

Letter of Recommendation

Please complete this reference form and return it directly to:

Department of Health
Midwifery Program
PO Box 47864
Olympia, WA 98504-7864

This is to certify that I have known _____

for ___ years, from _____ to _____ during which period

he/she was engaged in the study or active practice of midwifery.

To the best of my knowledge he/she is of good moral and professional character, is free from habits which might interfere with his/her professional activities and is worthy of holding a license to practice midwifery in the state of Washington.

Additional Comments _____

_____

_____

Note: No one is expected to sign this recommendation who does not know the applicant personally or who is not willing to supply additional information concerning this person's character, standing and education, upon request from the Department of Health.

Signature _____

Name (printed) _____

Address _____

City/State/Zip _____

Daytime Phone _____

Profession _____

Should you have any questions, please call the Midwifery Program at (360) 664-4216.

(This page intentionally left blank.)

Washington State Department of Health
Health Professions Quality Assurance
Midwifery Program
P.O. Box 1099
Olympia, WA 98507-1099

Letter of Recommendation

Please complete this reference form and return it directly to:

Department of Health
Midwifery Program
PO Box 47864
Olympia, WA 98504-7864

This is to certify that I have known _____

for ___ years, from _____ to _____ during which period he/she was engaged in the study or active practice of midwifery.

To the best of my knowledge he/she is of good moral and professional character, is free from habits which might interfere with his/her professional activities and is worthy of holding a license to practice midwifery in the state of Washington.

Additional Comments _____

_____

_____

Note: No one is expected to sign this recommendation who does not know the applicant personally or who is not willing to supply additional information concerning this person's character, standing and education, upon request from the Department of Health.

Signature _____

Name (printed) _____

Address _____

City/State/Zip _____

Daytime Phone _____

Profession _____

Should you have any questions, please call the Midwifery Program at (360) 664-4216.

(This page intentionally left blank.)

Washington State Department of Health
Health Professions Quality Assurance
Midwifery Program
P.O. Box 1099
Olympia, WA 98507-1099

Current Plan For Consultation, Emergency Transfer, and Transport

MIDWIFE NAME	DATE

1. The licensed physician who is engaged in active clinical obstetrical practice and with whom I will consult when there are significant deviations from the normal in either the mother or the infant is:

NAME	
ADDRESS	PHONE NUMBER

(If more than one consultant, use other side of form.)

2. In an emergency transport to a hospital the following are available:

(1) PRIVATE AMBULANCE CO	ADDRESS
(2) MUNICIPAL AID CAR	ADDRESS
(3) HELICOPTER SERVICE	ADDRESS
(4) HOSPITAL TRANSPORT SERVICE	ADDRESS

3. In the even of a maternal emergency in an out-of-hospital setting, I will transport to the following hospital(s):

NAME	LOCATION
NAME	LOCATION

4. In the even of a neonatal emergency in an out-of-hospital setting, I will transport to the following hospital(s):

NAME	LOCATION
NAME	LOCATION

MIDWIFE NAME	DATE

1a. Another licensed physician who is engaged in active clinical obstetrical practice and with whom I will consult when there are significant deviations from the normal in either the mother or the infant is:

NAME	
ADDRESS	PHONE NUMBER

1b. Another licensed physician who is engaged in active clinical obstetrical practice and with whom I will consult when there are significant deviations from the normal in either the mother or the infant is:

NAME	
ADDRESS	PHONE NUMBER

1c. Another licensed physician who is engaged in active clinical obstetrical practice and with whom I will consult when there are significant deviations from the normal in either the mother or the infant is:

NAME	
ADDRESS	PHONE NUMBER

1d. Another licensed physician who is engaged in active clinical obstetrical practice and with whom I will consult when there are significant deviations from the normal in either the mother or the infant is:

NAME	
ADDRESS	PHONE NUMBER

1e. Another licensed physician who is engaged in active clinical obstetrical practice and with whom I will consult when there are significant deviations from the normal in either the mother or the infant is:

NAME	
ADDRESS	PHONE NUMBER

1f. Another licensed physician who is engaged in active clinical obstetrical practice and with whom I will consult when there are significant deviations from the normal in either the mother or the infant is:

NAME	
ADDRESS	PHONE NUMBER

Washington State Department of Health

Disability Accommodation Request

Not Subject to Disclosure

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission. [Section 504 of the Rehabilitation Act (29 USC 12101)]. Please call (360) 664-4216 if you have questions about the types of accommodations available.

Name _____

Address _____

Phone _____ Social Security Number _____
(REQUIRED FOR LICENSE BY 42 USC 666 AND CHAPTER 26.23 RCW)

Accommodations requested for the _____ Midwifery examination.
DATE

I have the disability _____ and request the

following accommodation(s) at the testing site _____

_____

Name (please print) _____

Signed _____ Date _____

Documentation of Disability Related Needs

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate licensed health care professional (doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, for example in your midwifery education program, you may submit such documentation instead of having this portion of the form completed.

I have known _____ since _____ in my capacity as a _____.
TEST APPLICANT DATE PROFESSIONAL TITLE

The applicant has the disability _____

diagnosed by the following tests or studies _____

_____

I recommend the following accommodation(s) be provided for this individual _____

_____

Name (please print) _____

Address _____

_____ Telephone _____

Signed _____ Title _____

Date _____ License Number _____

Documentation from Midwifery education program.
If accommodations for testing were made for the candidate during progression through the Midwifery education program, please provide a letter from the director indicating what modifications were made.

(This page intentionally left blank.)

Washington State Department of Health
Health Professions Quality Assurance
Midwifery Program
P.O. Box 1099
Olympia, WA 98507-1099

Required Midwifery Courses

RCW 18.50.040
WAC 308-115-140

		Date	Course
1.	Obstetrics, normal & abnormal	_____	_____
2.	Neonatal Pediatrics/neonatology	_____	_____
3.	Basic Sciences	_____	_____
	Biology	_____	_____
	Anatomy with emphasis on female reproductive anatomy	_____	_____
	Physiology	_____	_____
	Genetics	_____	_____
	Embryology	_____	_____
4.	Childbirth Education	_____	_____
5.	Community Care	_____	_____
6.	Obstetrical Care	_____	_____
7.	Epidemiology	_____	_____
8.	Gynecology, normal & abnormal	_____	_____
9.	Family Planning	_____	_____
10.	Genetics	_____	_____
11.	Embryology	_____	_____
12.	Medical/Legal Aspects of Midwifery ..	_____	_____
13.	Nutrition during Pregnancy & Lactation	_____	_____

(Complete both sides of form)

		Date	Course
14.	Breast feeding	_____	_____
15.	Nursing skills to include:		
	Vital Signs	_____	_____
	Perineal Prep	_____	_____
	Enema	_____	_____
	Catheterization	_____	_____
	Aseptic Techniques	_____	_____
	Administration/Oral Medications	_____	_____
	Administration/Injections	_____	_____
	Local Infiltration of Anesthesia	_____	_____
	Venipuncture	_____	_____
	Administration of Intravenous Fluids	_____	_____
	Infant & Adult Resuscitation	_____	_____
	Charting	_____	_____

16. Student observed _____ births before graduation.
NUMBER

17. Student managed _____ births with a preceptor before graduation.
NUMBER

(Complete both sides of form)

Washington State Department of Health
Health Professions Quality Assurance
Midwifery Program
P.O. Box 1099
Olympia, WA 98507-1099

To: Applicants Examined And Licensed In Another State

RCW 18.50.065 states that, “An applicant holding a credential in another state may be credentialed to practice in this state without examination if the secretary determines that the other state’s credentialing standards are substantially equivalent to the standards in this state.”

Your application will be reviewed by the Department of Health and the Midwifery Advisory Committee.

Application Fee: $500

Application Instructions:

1. Complete in full the enclosed application. Carefully read and respond to the information requested in the Personal Attestation at the bottom.
2. A $500 fee must accompany the application. Make your check or money order payable to the Department of Health.
3. Attach one current passport type photograph (approximately 2 x 2 inches). Sign across the bottom or back of the photo. Instant pictures (Polaroids) are not acceptable.
4. Submit any documentation required for “yes” answers to any of the personal data questions.
5. Complete the Required Midwifery Courses form.
6. Fill out the first page of the form “Certification of Licensure and Examination” and send it to the jurisdiction in which you took your examination. Please request them to complete the second page (Verification of Original Midwifery Licensure) and have them submit this directly to this office along with a copy of the law you were licensed under and an outline of the examination you took. They may charge a fee for this service.
7. Transcripts should be sent directly from your Midwifery school to this office.
8. Submit a photocopy of your current midwifery license, showing your expiration date.

Please Note:

Applications will not be considered complete until **ALL** required supporting documents have been received by this department. Documents which are submitted in support of the application must use the same name as that on the application to prevent any delay in completing the process.

If a non-formal program has been completed, additional documentation may be required.

Approved Applications:

If, after review, your application is approved, you will be notified in writing and issued a midwifery license. Your expiration date will always be your birthday. The state of Washington does send courtesy renewal notices approximately 60 days prior to your expiration date but if for **any** reason you do not receive one, you will still be obligated to submit your renewal fee on or before your birthday. The late penalty fee will be due and payable on or before your birthday. The late penalty fee will be due and payable immediately after your expiration date without exception.

If you have any questions, you may call this office at (360) 236-4721.

Washington State Department of Health
Health Professions Quality Assurance
Midwifery Program
P.O. Box 1099
Olympia, WA 98507-1099

Certification Of Licensure And Examination

To the Applicant: Please complete the top portion of this form and send it to the state in which you took your midwifery state board examination. Have them return it directly to us at the address listed. (Duplicate this form if you are licensed in more than one jurisdiction.) The state licensing agency normally charges a fee for verifying your license, please check.

NAME LAST	FIRST	MIDDLE INITIAL

STREET ADDRESS		
CITY	STATE	ZIP
ANY OTHER NAMES USED		
NAME OF MIDWIFERY PROGRAM YOU COMPLETED		
MIDWIFERY LICENSE NUMBER	DATE ISSUED	

Have the licensing agency return this completed form to:	Department of Health Midwifery Program PO Box 47864 Olympia, WA 98504-7864
If you have any questions, please call (360) 236-4721.	

Certification Of Original Midwifery Licensure

(To be completed by State Agency)

To the Licensing Jurisdiction: Please complete this form with information regarding the applicant listed on the reverse side of this form. Send **a copy of the law** the applicant was licensed under **and an outline of the examination t**he applicant took. Submit to the address specified above. Thank you very much.

Name of Licensed Practitioner:	
State Providing Verification:	
Name Of Midwifery Program Completed:	
Number of years required:	Date Completed:
Date examination taken:	Examination Score:
Is Licensure Current? ☐ Yes ☐ No	Expiration Date:

Has this license ever been:

Suspended ☐ Yes ☐ No
Revoked ☐ Yes ☐ No
Surrendered ☐ Yes ☐ No (If yes, please provide explanation and supporting materials on a separate sheet.)

S
E
A
L

SIGNATURE

TITLE

STATE BOARD OR DEPARTMENT

DATE

(This page intentionally left blank.)

AGENCY CANDIDATES: INSTRUCTIONS
for taking the **NARM WRITTEN EXAMINATION**

In this packet are the:

- Agency registration form for the NARM Written Examination (form 500)
- *NARM Candidate Information Bulletin (CIB)*
- *HOW TO BECOME A CERTIFIED PROFESSIONAL MIDWIFE (CPM)*

1. Complete the Agency Application and return with the required fee to the address indicated.
2. If you wish to test at a site **other** than your state agency (an out-of-state site), please call the NARM Test Dept at 1-888-353-7089 for details.
3. After your Agency Application has been processed, you will receive a Letter of Admission from your state agency listing the test site address, the test time and the test date.
4. You must have the following items with you to be admitted to the test site?
   a. the Admission Letter from your agency with a current passport size photo of yourself attached; your original signature should be on the back of the photo.
   b. a second photo ID, such as a driver's license or passport

The proctor will retain the Admission Letter and photo for identification and verification purposes.

CANDIDATE INFORMATION BULLETIN (CIB)

The NARM CANDIDATE INFORMATION BULLETIN (CIB) contains the necessary information about become a Certified Professional Midwife (CPM) including Test Specifications (the Study Guide) for the NARM Written Examination and the NARM Skills Assessment.

Your Agency uses the NARM Written Examination as the final step of their licensure process. The Test Specifications (Study Guide) for the NARM Written Examination and general information pertinent to the NARM Written Examination are contained in the CIB.

The CIB also explains the total CPM process and how the NARM Written Examination fits into that process.

NOTE: Taking the NARM Written Examination as an Agency Licensing Examination **does not** entitle you to present yourself as a Certified Professional Midwife (CPM). Certification as a CPM **does not** entitle you to licensure in a state or province. Licensure requires approval by the designated Agency of your state or province. Certification as a CPM requires completion of the entire NARM Certification process.

Your name, address, social security number and pass/fail status will be kept on file to identify you as having taken the NARM Written Examination should you desire to complete the CPM Application Process. Included is the *HOW TO BECOME A CERTIFIED PROFESSIONAL MIDWIFE* brochure which gives you more information and return coupon for the CPM Application.

Pass/fail results of the Written Examination will be sent to the state agency 4-6 weeks after the test date. The agency will then notify each candidate of their results.

Licensure candidates generally take the NARM Written Examination at their state Agency site. However, all candidates are welcome to test at any of the other sites.

Agency candidates, regardless of their state of residence, must register for the NARM Written Examination through the process required by the state where they are seeking licensure. The state agency must give approval to NARM for that candidate to register to take the NARM Written Examination.

If a candidate chooses to take the NARM Written Examination at a site other than the agency site, the following conditions must be met:

1) The candidate must meet the eligibility requirements for the NARM Written Examination through the state agency,
2) The candidate must register and pay the appropriate fees,
3) The candidate must confirm with the NARM Test Department that the chosen site is available at least six weeks prior to the examination date. Not all sites are available on every date. The list below indicates which sites are usually available, but specific confirmation must be made prior to the testing date.

If approval is granted by the state agency, and the chosen test site and date are confirmed with the NARM Test Department, then NARM will send a confirmation letter to the candidate. NARM will also send the Candidate Admission Letter, with directions to the test site, approximately two weeks before the examination.

To be admitted to the test site, the candidate must bring:

1) The Candidate Admission Letter from NARM with a current passport-sized photo of yourself attached; your signature should be on the back of the photo;
2) A second photo ID, such as a driver's license or passport, for verification of identification.

The Candidate Admission Letter with attached photo will be retained by the examination proctor and kept by NARM for verification purposes.

Optional Test Sites for the NARM Written Examination:

NARM Sites:

___ Orlando, Florida
___ Atlanta, Georgia
___ Dubuque, Iowa
___ Wichita, Kansas
___ Pittsfield, Mass or St. Johnsbury, VT
___ Eugene, Oregon
___ Toledo, Ohio
___ Harrisburg, Pennsylvania
___ Nashville, Tennessee
___ Salt Lake (Murray) Utah
___ St. Thomas, Virgin Islands

Agency Sites:

State Agencies may let other candidates test at their site **IF** they are giving the examination to their own candidates on that test date. Permission must be requested through the NARM Test Deportment for other candidates to register for these sites. **NARM Test Department phone 1-888-353-7089**

Helena, Montana
Santa Fe, New Mexico
Columbia, South Carolina
Olympia, Washington
Juneau, Alaska
Little Rock, Arkansas
Phoenix, Arizona
Sacramento, California
New Orleans, Louisiana
Denver, Colorado
Austin, Texas

WASHINGTON
AGENCY CANDIDATE APPLICATION FORM (500)
for taking the NARM WRITTEN EXAMINATION

First Name _____ Last Name _____ Middle Initial ___

Address _____ Date _____

City _____ Province/State _____ Postal Code _____

Social Security # _____ Date of Birth _____ Country _____

Home Phone _____ Work Phone _____ Fax # _____

E-mail address _____

Are you a graduate of a Midwifery school? _____ Name of school _____
Is the school MEAC-accredited? _____ Date of graduation _____

The NARM Written Examination is given at ALL sites on the third Wednesdays of February and August, and one additional time only at the site and date of the annual MANA conference. Agency candidates may register for the February or August exam at their Agency site, and are also welcome to take the exam at the MANA conference. Please indicate below your choice of test dates and sites.

TEST DATE PREFERENCE:

____ **Agency Site,**
____ **Other Site** _____ (see registration form for list)

____ **February 19, 2002 (registration deadline January 9)**
____ **August 20, 2003 (registration deadline July 10)**
____ **MANA Conference, October 30, 2003, Austin, TX. (deadline Sept 30)**

Please enclose a **Certified Check or Money Order for $700 payable to NARM, (no personal checks)** and send it **prior** to the deadline, along with this form, to:
NARM Test Department
P.O. Box 7703
Little Rock, AR 72217-7703

For specific details about the Agency test site, please contact:
Kendra Pitzler or Shamim Noormuhammad
Midwifery Program, Department of Health
P.O. Box 47864
Olympia, WA 98504-7864
(360) 236-4723

Agency candidates will receive an Admission Letter and instructions to the test site from the state agency. Agency candidates who wish to take the exam at another site or at the MANA conference must register through the agency, but will receive the Admission letter and site directions from NARM. Individual test scores will be sent to the Agency address and reported to each individual by the Agency.